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Kerkhof, A.J.F.M.; Hulten, A.; Wasserman, D.; Hawton, K.

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E-mail address:

vuresearchportal.ub@vu.nl

A. Hultén
D. Wasserman
K. Hawton
G.-X. Jiang
E. Salander-Renberg
A. Schmidtke
U. Bille-Brahe
T. Bjerke
A. Kerkhof
K. Michel
I. Querejeta

Recommended care for young people (15–19 years) after suicide attempts in certain European countries

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A. Hultén (✉) · D. Wasserman
G.-X. Jiang
Swedish National Centre for Suicide
Research and Prevention of mental illhealth
at the National Institute for Psychosocial
Factors and Health/Department of Public
Health Sciences, Karolinska Institute
Box 230, SE-171 77 Stockholm, Sweden
Tel.: + 46 8 7287026, Fax: + 46 8 306439

K. Hawton
University Department of Psychiatry
Warneford Hospital, Oxford OX3 7JX, UK

E. Salander-Renberg
Psychiatric Institute, University of Umeå
S-901 85 Umeå, Sweden

A. Schmidtke
Universitäts Nervenlinik
Füchslinstrasse 15
D-97080 Würzburg, Germany

U. Bille-Brahe
Unit for Suicidological Research
Tietgens Allé 108
DK-5230 Odense M, Denmark

T. Bjerke
Department of Education
and Social Science, Lillehammer College
P.O. Box 1004 Skurva
2610 Lillehammer, Norway

A. Kerkhof
Department of Clinical Psychology
Vrije University Amsterdam
De Boelelaan 1009
1081 HV Amsterdam, The Netherlands

K. Michel
Psychiatrische Universit  tspoliklinik
M  rtenstrasse 21
CH-3010 Bern, Switzerland

I. Querejeta
Hospital de Guipuzcoa
Servicio de Psiquiatr  a
20014 San Sebastian, Spain

Abstract Data on recommended care for young people aged 15–19 years after attempted suicide from nine European research centres during the period 1989–1992 were analysed in terms of gender, history of previous suicide attempt and methods used. Altogether 438 suicide attempts made by 353 boys and 1,102 suicide attempts made by 941 girls were included. Analyses of the total data from all centres showed that young people with a history of previous suicide attempt and those using violent methods had significantly higher chance of being recommended aftercare than first-time attempters or those choosing self-poisoning. There were no significant differences of being recommended care between genders. Logistic regression analyses of the material were performed and the results were similar. Both having previous attempted suicide (odds ratio 2.0, 95% CI 1.53–2.61) and using “hard” methods (odds ratio 1.71, 95% CI 1.49–1.96) were significantly associated with increased possibility of being recommended aftercare. When individual centres were analysed, large disparities of recommended care after suicide attempts were found and there were no uniform criteria of recommending care for young suicide attempters in Europe.

Key words Young people – attempted suicide – method – recommended care

Introduction

Suicide and attempted suicide (parasuicide) represent a growing health problem both in Europe (9) and in the rest of the world, thus imposing a heavy burden on national health care resources (26). A recent Swedish study (11) has shown how treatment and care for young people before completed suicides were characterised by a lack of continuity in terms of the medical team involved and the treatment applied.

The findings of several surveys (4, 10, 16, 17, 29) show that a history of previous suicide attempts is an important indicator for repeated attempts and future suicides, and also that individuals with the highest risk for completed suicide are males who have used violent methods in their suicide attempts (15, 27).

Until now, there have been no international studies concerning the care recommended for young people in Europe after attempted suicide. One reason is that it has been difficult to obtain comparable data on suicide attempts, owing to disparities in definitions and problems of survey design. In order to avoid these problems, the European WHO working group initiated a joint project with the overall aim of preventing suicidal behaviour in Europe (24). Since the project started in 1989, a total of 16 research centres in 13 European countries have registered all attempted suicide patients aged 15 years and above who have received health care as a result of their overdose or self-injury (24, 28). All these participating centres use the same questionnaire and identical registration procedures for individuals treated at the hospital following attempted suicide. Extensive European material on registered suicide attempts has now been collected.

There are several population-based self-report studies regarding self-harm and need of care after attempted suicide in adolescents (14, 18, 25, 34). Only a few studies have presented data on referral to treatment in adolescent suicide attempters (5, 19, 30, 32).

Results of a surveillance study among high school students in the U.S. (14) showed that 7.7% of the students had attempted suicide during the 12 months preceding the survey, and only 2.6% of students reported having made a suicide attempt during the 12 months preceding the survey that had been treated by a doctor or nurse.

In a study from the U.S., psychiatric consultation was requested for only half of those who survived their violent self-harm acts (5). In another study from the U.S., of 78 adolescents seen in an emergency department, 17.5% never attended aftercare (30).

In three self-report studies from Sweden on adolescents and their experiences of help after suicide attempt (18, 25, 30), 3% of boys and 7% of girls reported that they had attempted suicide during their lifetime. Ap-

proximately less than half of the adolescents in the above quoted investigations visited an emergency department for help after their suicide attempt.

The purpose of the present study was to describe recommended care, i.e. the recommended next stage of health care, for young people aged 15–19 years after attempted suicide, and to analyse the association of recommended care with relevant factors, like gender, previous suicide attempt(s) and the methods used for the suicide attempts, from nine European centres during the period 1989–1992 in which data were available and accepted for publishing.

The hypothesis of the study was that the relative chance of being recommended care should be higher for boys than for girls because of their greater risk for suicide. The chance should also be greater for individuals who have previously attempted suicide than for those attempting suicide for the first time. The chance of being recommended care should be higher for young people who used violent methods in their suicide attempts than for young people whose method of attempting suicide was self-poisoning.

Material and methods

Centres included in the study

Data on recommended care were studied from nine European centres participating in the WHO/EURO Multicentre Study on Attempted Suicide (Parasuicide) during the period of 1989–1992. These centres were Bern (Switzerland), Guipuzcoa (Spain), Leiden (The Netherlands), Odense (Denmark), Oxford (United Kingdom), Stockholm and Umeå (Sweden), Sør-Trøndelag (Norway) and Würzburg (Germany). All the centres carried out registration of patients who had attempted suicide and received hospital emergency somatic treatment during the study period, except that in Bern registration took place only in the years 1989–1990, and in Guipuzcoa only in 1989–1991.

Material

Data reported in this study were analysed with reference to each event of attempted suicide. Altogether, 1,540 attempted suicide events involving 353 boys and 941 girls aged 15–19 years were registered in the nine centres during 1989–1992.

Information regarding the variables of age and gender was missing in 15 cases (1%). The answer for the variable “recommended next stage of health care” was missing for 137 (9%) of 1540 attempted suicide events (Table 2). Data on the variable of previous

suicide attempt(s) were missing for 315 (20%) of the attempted suicide events.

Information on the variable of method used in the suicide attempt was incomplete in 49 (3%) of the events. In the analysis of the chances of the young suicide attempters being recommended aftercare when using "hard" and "soft" methods of attempting suicide (X70–X84 and X60–X69, respectively), data were missing in 172 events.

Methods

In the monitoring project of the WHO/EURO Multi-centre Study on Attempted Suicide (Parasuicide), there is an item about "recommended next stage of health care" after attempted suicide in a joint questionnaire (1). This item is named only as "recommended care" in the following text and used to describe the care recommended after the conclusion of emergency somatic treatment following attempted suicide, which may involve psychiatric care on an outpatient or inpatient basis, with a psychiatrist, psychologist and/or counsellor for psychotherapy or, alternatively, critical or supportive contact for both the individual and the family concerned. All other forms of support and help unconnected with psychiatry are also included in this variable. For example, young people may be referred to a school counsellor, youth reception, social-welfare office, centres for treatment of alcoholism, general practitioner or private care providers. Referral back to general practitioner care alone was not included as a specific aftercare.

Recommended care in this survey has been classified into several categories: psychiatric care as outpatients or inpatients, and non-psychiatric care as out-hospital care. Different kinds of recommended care after suicide attempts, separately or in combination, were compared with "no care recommended" at all in association with relevant variables, like gender, history of previous suicide attempts and methods used.

The data from these nine centres were analysed with reference to each event of attempted suicide for the entire material as a whole and for each centre separately.

"Relative risk" (RR), which in this article expresses the probability of being recommended care after suicide attempt, has been calculated for the following variables: (a) the female-male gender, (b) the presence of previous suicide attempt(s) (PSA) in relation to "first-ever" suicide attempt (FE) and (c) various methods of attempting suicide.

The ICD-10 code (12) used in the questionnaire in this study permits one to classify methods used for attempted suicide into 25 different categories. Methods X60–X69 are those that may be designated as "soft", including self-poisoning with medication, drugs or other

substances. Methods X70–X84 relate to self-harm of violent ("hard") nature, i.e. attempted suicide by hanging, jumping or cutting by sharp objects, etc.

The aftercare recommended for individuals who chose "hard" methods of attempting suicide (X70–X84) was compared with that for those who chose "soft" methods (X60–X69). The recommended care for young people who have attempted suicide for the first time and for repeaters was also analysed, according to the three most common methods of attempting suicide: self-poisoning with non-narcotic analgesics (X60), self-poisoning with barbiturates, other sedatives, hypnotics and psychotropic agents (antidepressants) (X61); and self-harm by sharp objects (X78). The analyses were carried out in such a way that pharmacological agents available by prescription only (X61) and cutting with a sharp object (X78) were compared with the use of analgesics for sale over the counter (X60).

A stepwise logistic regression analysis was also performed. The dependent variable is recommended care, and the analysed variables as predictors are age, gender, history of previous attempted suicide and method of attempted suicide as "soft" and "hard".

When data for one or more variables were not available for certain attempted suicide events, these events were excluded for particular comparative purposes. Accordingly, the number of attempted suicide events is not always the same for the various comparisons presented in the tables.

Significance levels were calculated by means of the chi-square test and Fisher's exact test, while 95% confidence intervals (CI) were supplied for relative risk values.

Results

Altogether, 1,540 attempted suicide events involving 1,294 people aged 15–19 years were registered during 1989–1992. There were 438 attempted suicide events among 353 males and 1,102 events among 941 females with an uneven distribution between the centres. Bern reported that 52 young people were involved in 54 suicide attempt events, and 29 individuals in Guipuzcoa had made 30 suicide attempts. In Leiden there were a total of 67 suicide attempts made by 65 young people, while Odense registered 163 young people and 192 attempted suicide events. Oxford showed the largest number of people, 585, and 720 attempted suicide events. Stockholm reported that 112 young people were involved in 120 attempted suicide events and 127 young people in Sør-Trøndelag had made 139 suicide attempts. Umeå had registered 87 young people with 129 attempted suicide events. Finally, in Würzburg 74 individuals and 89 attempted suicide events were registered.

The mean person rates per 100,000 person-years of attempted suicide for males among the nine centres varied from 29.9 (Guipuzcoa), 47.5 (Leiden), 68.7 (Bern), 105.2 (Sør-Trøndelag), 107.5 (Odense), 120.8 (Würzburg), 126.0 (Stockholm and Umeå), 68.7 (Bern), to 301.8 (Oxford). The corresponding values for girls were from 125.6 (Guipuzcoa), 186.0 (Leiden), 217.8 (Sør-Trøndelag), 240.2 (Odense), 262.7 (Bern), 395.8 (Würzburg), 534.2 (Stockholm and Umeå), to 769.2 (Oxford).

Of the boys 66%, and 65% of the girls were first-ever suicide attempters. The proportion of repeaters was almost unchanged during the period studied. Of the 1,294 young boys and girls studied, 60% lived with their parents, 12% alone and the remaining with other relatives, friends, partners, in foster homes or in various institutions.

There were differences of recommended care after attempted suicide among the centres. Results regarding recommended care are presented in Table 1, separately for gender and for patients who had attempted suicide for the first time or had made previous suicide attempts.

Recommended care after suicide attempt and gender

Results obtained by analysing the total material from the nine centres did not demonstrate a significant overrepresentation of girls being recommended aftercare compared with boys (Table 2). The table is arranged in alphabetical order on centre names. In six individual centres, Leiden, Odense, Oxford, Stockholm, Sør-Trøndelag and Umeå, girls had a greater chance of being recommended aftercare than boys, but the figures did not reach statistical significance. The reverse situation prevailed in three of the nine centres, Guipuzcoa, Würzburg and Bern, i.e. overrepresentation of boys being recommended aftercare was more pronounced, but again without statistical significance.

Table 2 Relative risk (RR) with 95% confidence intervals (CI) of recommended care after suicide attempts between females and males aged 15–19 years

Centre	Recommended care			
	Gender	Yes	Not	RR (95% CI)
Bern	Male	6	0	1
	Female	27	8	0.77 (0.00–3.60)
Guipuzcoa	Male	5	1	1
	Female	18	6	0.90 (0.01–7.33)
Leiden	Male	6	6	1
	Female	24	20	1.09 (0.58–2.04)
Odense	Male	55	18	1
	Female	92	27	1.03 (0.87–1.21)
Oxford	Male	125	86	1
	Female	289	192	1.01 (0.89–1.16)
Stockholm	Male	15	2	1
	Female	61	2	1.10 (0.27–59.00)
Sør-Trøndelag	Male	12	8	1
	Female	55	14	1.33 (0.76–8.57)
Umeå	Male	20	4	1
	Female	97	2	1.18 (0.98–1.41)
Würzburg	Male	17	0	1
	Female	56	12	0.82 (0.00–1.35)
Total	Male	261	125	1
	Female	719	283	1.06 (0.98–1.15)

Recommended aftercare and history of previous suicide attempts

The overall results regarding recommended care for patients of both genders who had attempted suicide for the first time and those who had previous suicide attempt(s) are presented in Table 1. The highest proportion of recommended aftercare, 81%, was seen in girls who had attempted suicide previously. Of boys who had previously attempted suicide, 76% were recommended aftercare.

In all centres boys with previous suicide attempts were recommended aftercare to a greater extent than

Table 1 Numbers and percentages of recommended care for first-ever suicide attempters and previous suicide attempters aged 15–19 years

Centre	Recommended care for FE ^a			Recommended care for PSA ^b		
	Male/Female	Male (%)	Female (%)	Male/Female	Male (%)	Female (%)
Bern	2/11	100	91	2/13	100	85
Guipuzcoa	3/15	67	73	3/9	100	78
Leiden	9/30	44	53	3/12	67	58
Odense	17/35	76	86	29/22	90	77
Oxford	93/216	55	50	91/187	67	72
Stockholm	10/34	90	100	6/24	100	100
Sør-Trøndelag	11/29	64	69	7/34	71	85
Umeå	16/28	94	93	5/67	100	100
Würzburg	8/29	100	76	6/36	100	86
Total	169/427	66	65	152/404	76	81

^a FE first-ever suicide attempt, ^b PSA previous suicide attempt

boys for whom the current attempt was their first time ever. Regarding the girls also for all centres, with the exception of Bern and Odense, recommended aftercare occurred more often to those with previous suicide attempts.

Results from the individual centres showed that in two centres, Stockholm and Umeå, aftercare was recommended to all boys and girls who had attempted suicide previously.

When gender was concerned (Table 2), the analyses showed that in Bern, Guipuzcoa, Leiden, Odense and Würzburg aftercare was recommended for a higher proportion of boys with a history of previous attempted suicide than for girls of the corresponding group. The opposite was observed in Oxford and Sør-Trøndelag where, among those who had made a previous suicide attempt, more girls than boys were recommended aftercare. The differences were, however, non-significant.

Results presented in Table 3 show that young people who had made previous suicide attempts had, overall, a significantly higher chance of being recommended aftercare than those whose current suicide attempt was the first, but the figures varied widely between individual centres and statistically significant values were found only in Oxford. Bern was an exception: there, young people with a history of previous attempted suicide had a lower chance of being recommended care after suicide

attempt (without statistical significance) than young people who had never previously attempted suicide.

Recommended aftercare in relation to different methods of attempting suicide

When analysing the total material for all the nine centres, the young people who had chosen "hard" methods for their suicide attempts (X70–X84) had a higher chance of being recommended aftercare than those choosing "soft" methods, i.e. self-poisoning with prescription or non-prescription drugs (X60–X69), whether they had a history of previous attempted suicide or not (Table 4). When individual centres were studied, significant results were only obtained for Umeå and Würzburg.

A comparison between the three predominant methods used in suicide attempts (Table 5) showed that aftercare was more likely to be recommended following self-poisoning with prescription drugs (X61, e.g. sedatives and antidepressants) and cutting with a sharp object (X78) than when non-prescription drugs (X60, usually analgesics such as paracetamol) had been taken. The chance of being recommended aftercare was, however, highest for young people without a history of

Table 3 Relative risk (RR) with 95% confidence intervals (CI) of recommended care after suicide attempts between previous suicide attempters and first-ever suicide attempters aged 15–19 years

Centre	Recommended care			
	SA ^a	Yes	Not	RR (95% CI)
Bern	FE ^b	12	1	1
	PSA ^c	13	2	0.94 (0.01–11.94)
Guipuzcoa	FE ^b	13	5	1
	PSA ^c	10	2	1.15 (0.24–23.72)
Leiden	FE ^b	20	19	1
	PSA ^c	9	6	1.17 (0.70–1.96)
Odense	FE ^b	43	9	1
	PSA ^c	43	8	1.02 (0.86–1.21)
Oxford	FE ^b	159	150	1
	PSA ^c	196	82	1.37 (1.20–1.56)*
Stockholm	FE ^b	43	1	1
	PSA ^c	30	0	1.02 (0.98–1.07)
Sør-Trøndelag	FE ^b	27	13	1
	PSA ^c	34	7	1.23 (0.95–1.59)
Umeå	FE ^b	41	3	1
	PSA ^c	72	0	1.07 (0.99–1.16)
Würzburg	FE ^b	30	7	1
	PSA ^c	37	5	1.09 (0.90–1.32)
Total	FE ^b	388	208	1
	PSA ^c	444	112	1.23 (1.14–1.32)*

^a SA suicide attempt, ^b FE first-ever suicide attempt, ^c PSA previous suicide attempt, * significantly different

Table 4 Relative risk (RR) with 95% confidence intervals (CI) of recommended care after suicide attempts between those with "hard" methods and those with "soft" methods aged 15–19 years

Centre	Recommended care			
	Methods	Yes	Not	RR (95% CI)
Bern	Soft ^a	24	7	1
	Hard ^b	7	0	1.29 (–)
Guipuzcoa	Soft ^a	22	6	1
	Hard ^b	1	1	0.64 (0.00–24.95)
Leiden	Soft ^a	22	22	1
	Hard ^b	8	4	1.33 (0.81–2.19)
Odense	Soft ^a	109	33	1
	Hard ^b	38	12	0.99 (0.83–1.19)
Oxford	Soft ^a	352	247	1
	Hard ^b	52	27	1.12 (0.94–1.33)
Stockholm	Soft ^a	63	3	1
	Hard ^b	13	1	0.97 (0.05–34.97)
Sør-Trøndelag	Soft ^a	55	18	1
	Hard ^b	11	4	0.97 (0.23–4.36)
Umeå	Soft ^a	50	6	1
	Hard ^b	65	0	1.12 (1.02–1.23)*
Würzburg	Soft ^a	35	11	1
	Hard ^b	38	1	1.28 (1.08–1.52)*
Total	Soft ^a	732	353	1
	Hard ^b	233	50	1.22 (1.14–1.31)*

^a Soft self-poisoning by any of the methods X60–X69 (medication, drugs, chemicals, see text under methods), ^b Hard self-harm by any of the methods X70–X84 (hanging, jumping, see text under methods), * significantly different

Table 5 Relative risk (RR) with 95% confidence intervals (CI) of recommended care after suicide attempts among nine European centres, taking various methods of attempting suicide into consideration, for previous suicide attempters and first-ever suicide attempters aged 15–19 years

Suicide attempt	Recommended care			
	Methods	Yes	Not	RR (95% CI)
FE ^a	X60 ^c	137	119	1
	X61 ^d	110	32	1.45 (1.25–1.67)*
FE ^a	X60 ^c	137	119	1
	X78 ^e	50	12	1.51 (1.28–1.78)*
PSA ^b	X60 ^c	166	51	1
	X61 ^d	77	20	1.04 (0.92–1.18)
PSA ^b	X60 ^c	166	51	1
	X78 ^e	113	17	1.14 (1.03–1.26)*

^a FE first-ever suicide attempt, ^b PSA previous suicide attempt, ^c X60 self-poisoning by barbiturates, other sedatives, hypnotics and other psychotropic agents, ^d X61 self-poisoning by non-narcotic analgesics, antipyretics and antirheumatics, ^e X78 self-harm by sharp object, * significantly different

previous suicide attempts when they used cutting with a sharp object or self-poisoning with prescription drugs as the method of attempting suicide. Those who had made one or more previous suicide attempts also had a statistically significantly higher chance of being recommended aftercare if they used cutting with a sharp object as the method at the suicide attempt.

The results of logistic regression analysis were based on 1,152 attempted suicide events with available relevant information. The variables of “previous attempted suicide” and “method of attempted suicide” were included in the final model. Both having previous attempted suicide (odds ratio 2.0, 95% CI 1.53–2.61) and using “hard” methods (odds ratio 1.71, 95% CI 1.49–1.96) were significantly associated with increased possibility of being recommended aftercare. The variables of age and gender were excluded from the model.

Different kinds of recommended care after suicide attempts

When the analyses were repeated for comparisons of the three different kinds of care recommended (outside hospital, out- and inpatient psychiatric care) separately and in combination, with no care at all, there were no generally major changes in relative risks observable. Separately, in the centre of Oxford the chance of being recommended psychiatric inpatient care after a suicide attempt was significantly higher for repeaters (RR 5.86, 95% CI 2.66–12.90). If “hard” methods were used, the chance was also significantly higher in Würzburg (RR 1.52, 95% CI 1.15–2.02) and Oxford (RR 3.30, 95% CI 1.94–5.59).

Discussion

This is the first study on recommended care for young people who attempted suicide with comparable data from several European countries. When overall data were analysed, the results confirmed the hypothesis tested that aftercare was recommended significantly more often for young persons with a history of previous suicide attempts and those choosing violent methods. At the same time marked differences between centres were revealed when analysing data for individual centres.

Methodology

Tests on the validity of the collected data in the WHO Monitoring Study have been made in every centre. This was described previously by Kerkhof et al. (13). It seems that differences in attempted suicide rates do not depend on the lack of validity but on real differences among the centres. Such a difference of rates is also found in adults who attempted suicide (28) and who committed suicide (35).

The amount of missing information varied between variables and individual centres. For the variables of age and gender, the number of missing values was so small as to be negligible. For the variables of recommended next stage of health care and previous suicide attempts, the missing data were 9% and 20% respectively, while for the method of attempting suicide variable non-respondents made up only 3%. One possible explanation of the differences in missing data may be prompt self-discharge from the emergency department in some cases. The interviewer was able to conduct only brief interviews, with incomplete answers, owing to lack of time. Information about age, gender and method of suicide attempt is readily obtainable from case records, but this does not always apply to a history of previous episodes and of the aftercare recommended.

Recommended aftercare

In the material from the WHO study on attempted suicide with patients aged 15 years and over during the survey period, 16% of the men and 14% of the women had not been recommended care after emergency medical treatment due to suicide attempt (28). For the youngest age group, 15–19 years, to which this article refers, the figures were alarmingly high: 29% for boys and 26% for girls. This might be interpreted as showing that the attempted suicide events in young people were taken less seriously or, alternatively, that young people had a more negative attitude towards continued help, which doctors did not address.

A negative attitude towards health care personnel, adults and help may be partly connected with the development phase in young people. The drive to achieve autonomy is very strong in the teenage years, and threats to lose independence, as for example hospital care, can be experienced with anguish – something that needs to be taken into account in the treatment of young people. According to Spirito (30), one-quarter of the young people admitted to the hospital denied, immediately on arrival, that the event had been a suicide attempt, and an equally high proportion retracted their admission the following day. Parents' lack of assistance may also underlie such behaviour. If the attitude of parents towards care is negative or they treat the event as trivial, it is more difficult for a teenager to accept help (21). Parents' attitude towards care is important, since parents serve as models for their children in the treatment situation, regarding treatment compliance as in other respects.

Differences of recommended aftercare for girls and boys between centres

Females, generally and in six of the nine centres, had a non-significantly higher chance of being recommended care after suicide attempts, while in Würzburg, Guipuzcoa and Bern instead boys were recommended aftercare to a greater extent than girls. Würzburg and Bern are geographically close to each other, but Guipuzcoa in northern Spain is remote. One explanation for this finding can be different care traditions between the centres.

The most surprising findings are differences between centres, in terms of care recommended, that emerge from analysis with reference to gender and comparison of youngsters with a history of previous suicide attempts with those who had just attempted it for the first time. These results could be interpreted as showing that boys have less chance than girls of being recommended aftercare. While girls repeat suicide attempts more often, they take their own lives less often than boys, which should entail a higher rate of care for boys. But the difference in recommended aftercare registered in this study may perhaps be due to a more negative attitude towards care among boys than among girls of the same age (6, 8), as well as due to more negative attitudes of clinicians to boys with suicide attempts who have personality disorders (2, 31–33).

Recommended aftercare for repeaters

The present study showed that the proportion being recommended care after suicide attempts was highest among girls and boys with a history of previous

attempted suicide (81% and 76%), compared to youngsters of both genders being recommended care after their first suicide attempt (around 65%). Therefore, it is remarkable that 24% of the boys, who were repeaters, were not recommended aftercare given that boys run a higher risk of repeating suicide attempts (22, 23) and dying from (completed) suicide (7, 15, 27, 29) than girls. One reason for this fatal outcome in suicide is a high proportion of personality disturbances in boys who repeat suicide attempts.

When recommended aftercare for young people with a history of previous attempted suicide was compared with that for those who had attempted suicide for the first time in each individual centre, it emerged that a consistent policy in Europe regarding recommendations of aftercare is lacking. Only in Oxford statistically significant figures were shown. Individual centres should recommend care more often for young people with a previous history of attempted suicide, since previous attempted suicide has been proved to be among the most important predictors for both future repeated suicide attempts and completed suicides. One reason for this is that personality disorders are correlated with repeated suicide attempts (3, 20). It is desirable that health care services should be able to offer effective treatment programmes for these individuals.

Recommended aftercare and methods used for attempting suicide

Overall, young people who had attempted suicide by cutting with a sharp object, hanging, jumps from heights or other "hard" methods had a significantly greater chance of being recommended care after suicide attempts than when "soft" methods, i.e. self-poisoning with prescription or non-prescription drugs were used.

When individual centres were studied this pattern was only seen in Würzburg and Umeå. The nine centres were inconsistent in terms of the aftercare recommended for young suicide attempters.

There was no joint policy even for those who had used the same method in their suicide attempts. The use of "hard" methods should confer a greater chance of being offered aftercare, since this type of attempted suicide is associated with a higher suicide mortality (4, 23). One explanation for this fact may be that the "hard" methods largely consisted of, in girls, using a sharp object to cut the wrist, an act that may have been assessed as a more anguish-relieving gesture than a serious suicide attempt. Many adolescent girls use this method which from a clinical point of view is often less harmful.

On the other hand cutting in female adolescents is mentioned as pathologic self-mutilation in conjunction with borderline personality disorders. Self-mutilation

behaviour is also associated with serious psychiatric diagnoses, e.g. alcohol abuse, bulimia, antisocial behaviour and impulsiveness, and the health care services have difficulties in offering good methods of treatment for this group of patients.

Recommended psychiatric care after suicide attempts

Analyses of different kinds of care, including psychiatric care (inpatient or outpatient) and non-psychiatric care (out-hospital), after suicide attempts, show a similar tendency, i.e. no significant difference between genders but significant differences between adolescents with previous suicide attempt(s) compared to those registered for their first suicide attempt and between "hard" and "soft" methods used. It may indicate that all three kinds of care recommended were similarly associated with those variables.

Conclusion

The results of the present study show marked differences between individual centres regarding the care they recommended for young people after suicide attempts. Evidently uniform lines of assessment and treatment regarding aftercare for young people who attempted suicide in Europe are lacking, and that different countries assign different priorities to this kind of care. Further work is desirable, i.e. to investigate the reasons for these differences and what implications they have for the outcome.

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